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DISCREPANCIES IN SOCIAL WORKERS' SELF-PERCEPTION IN
THEORETICAL AND TREATMENT APPROACHES TO DEPRESSED
LATE MIDDLE-AGE WOMEN

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Enid Aida Velasco
September 1997

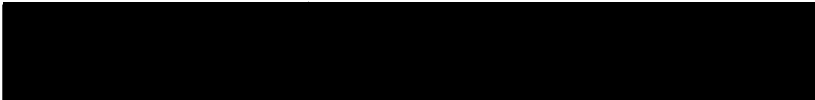
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September 1997

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9/11/97
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Dr. Teresa Morris, Chair of Research Sequence,
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ABSTRACT

This study proposes to assess discrepancies in Social workers' perceptions of their theoretical formulations of the causes and treatment of depression in later middle-age women and the treatment processes they actually follow. The study sought to elicit a dichotomy between social workers' theoretical orientations and their approach to treatment of depression in potentially menopausal women.

Three treatment plans were posited against one vignette. The treatment plans elicited a primary orientation toward the biological or toward a psychosocial model, or toward a feminist model of assessment and treatment. Answers to the survey questions were correlated to demographic information about the respondents.

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INTRODUCTION

Problem Statement

Social workers provide the majority of mental health treatment services in the United States (California Society for Clinical Social Work, 1996). As practitioners, their theoretical orientations fall into all categories of mental health and social services. Also, one large group of clients treated by social workers are depressed clients, a majority of whom are women. This study proposes to examine discrepancies between social workers' theoretical orientation to the treatment of middle-age depressed women and the actual treatment approach social workers use.

The diagnosis of depression among women, has historically been attributed to the decline of their generative organs. An example of the use of women's generative organs in medical terminology is the Greek word "hustera", meaning uterus, hence, hysteria (which means wandering uterus). This was considered a condition of disordered behavior ascribed solely to women and related to the wandering of the uterus. Today hysteria is no longer applied to just women, but there still remains a negative association between reproductive processes and psychiatric

disorders in women.

Biscoe (1982) pointed out that women have an excess of negative affective disorders over men. A rationale for the excess of negative affective disorders in women is the increase of reported depression as women get older, they admit more freely to emotional symptoms than men (Hobbs et al, 1984), as well as, it is much more socially acceptable for women to have gynecological complaint rather than a psychiatric one (Ballinger, 1990). Either way, a complex phase of a woman's life explained away in a simplistic manner and is viewed in a negative way.

Phyllis Chesler (1989) pointed out that some "women become depressed long before menopausal chemistry becomes the standard explanation for the disease" (pg.41). Although some women do get depressed as they get older, some contributing factors may be; limited opportunities for emotional, intellectual, and sexual growth; these opportunities may have decreased in the aging process or because of negative societal attitudes toward age (Chesler, 1989). More specifically, depression may result from deep-seated psychological fear of aging society has imposed on women (e.g., fear of losing their attractiveness and becoming less desirable and powerless).

Peplau and Campbell (1989) found that, in male and female relationships, the more attractive person the more power they have over their partner, if the partner perceives a difference. The partner may display jealousy and suspicion, this can then become a coercive tool between partners. Therefore, fear of aging in some women and their loss of power, as a reason for feeling depressed.

Women are more likely than men to go to health care agencies which they can be identified with psychiatric disorders (Gove & Tudor, 1973; Mechanic, 1978). Since women are more likely to seek medical help, they also are consumers of pharmaceutical medication for depression, and a hormonal imbalance.

Since all women experience menopause, and this stage of a women is considered a medical problem, pharmaceutical companies have capitalized in researching and creating new drugs. Klein & Dumble (1994) point out that women are currently in the middle of "technopatriarcy's institutions". In other words, women are in the middle of a tug-of-war between medical experts such as pharmaceutical companies, and the media who claim that hormones such as estrogen and progesterone, are essential for the rest of middle age women's lives, and this prescription will ease the process

of "the death of our ovaries". Additionally, Klerman et al. (1985) found a progressive increase in the predominance of depression in younger cohorts, coupled with the coming of age of the "baby boomer generation" (Brown & Harris, 1978; Kline & Dumble, 1994), pharmaceutical companies have targeted the middle age population for their research.

Studies have been done to disprove the notion that depression is a normal part of growing older. Zonderman and Costa (1991)'s analysis of the National Examination Follow-Up Study found no correlation between gender and depressive symptoms when controlling for age (in a cohort age 32-86). There was a slight increase in the age cohort of 75-86, and among women, depression was slightly, but not significantly higher in all age cohorts.

Other investigators have found that among older persons in the community, depression is not as high as among those in institutional settings, in fact rates are higher than those who live in their community (Berkman et al., 1986; Blazer and Williams, 1980; Blazer et al., 1987, 1991; Murrell et al., 1983; Zonderman and Costa 1991). Pramelee et al. (1989) found the incidence of depression among residents in a long term facility to be 2.4%. Therefore, depression maybe more likely depending on social factors,

physical health and social support systems.

Another factor is that older patients tend to seek mental health care from their primary physicians (Callahan et al., 1994). McKinlay et al. (1987) suggests, the literature indicated the lack of recognition and treatment of depression in a primary care facility.

All of these studies indicate there is a need for additional diagnostic categories to better serve the middle age population and prevent counter productive treatment and premature hospitalization.

Theoretical Perspectives

There are two divergent perspectives and an alternative perspective not readily recognized in the enormous body of research regarding depression among potentially menopausal women. One, states that middle age women suffer depression due to hormonal or menstrual change (biological). Another, suggests that depression is due to social circumstances during the middle aged years (social). A third potential approach in the treatment of depression in late-middle age women is the feminist perspective.

The Biological Model

This view maintains that depression is triggered both by the onset of menses and the cessation of the menstrual cycle. Not all gynecologists share this value. Conversely, Ballinger (1990) points out that this school of thought continues to list depression as a specific symptom of menopause in the standard gynecological textbooks. Gynecologists continue to relate the presence of psychiatric characteristics to menopause and oestrogen [sic] deficiency (e.g. Studd, 1979). Malleson (1953) ascribed menopausal depression to the lack of oestrogen and the strong conviction of Wilson & Wilson (1963) who wrote a paper called, "The fate of the non-treated post-menopausal women: a plea for the maintenance of adequate oestrogen from puberty to the grave." Wheatly (1991) points out that neither Studd (1990) nor Ballinger (1990) take into consideration the potential link between depression and hormone therapy, that is progesterone-induced depression.

Social Factors Perspective

This perspective points out that neither the person nor the environment can be assessed accurately in isolation from each other. Social factors theorists ask questions such as,

"How do we know what personality or environmental dimensions are relevant to human functioning?" Can they address these issues in depression, and if they can be isolated or generalized to all persons (Wetzel, 1978).

Wetzel (1978), for example, looked at fifty depressed white women between 18-75 years of age and fifty non-depressed women who were matched for age for sex, race, age, and occupation. Another study was a cross-cultural study of 300 Anglo-Americans, African-Americans, and Mexican-Americans, men and women, half of whom were not depressed were matched with the depressed group. Wetzel and Redmond, (1980) found that, regardless of culture, age cohort, gender, the quality of subjects' family support, their feelings of dependency, and their perception of being controlled at work, were significant predictors of depression. The social factors perspective identifies risk factors such as stressful life events, family conflict, and absence of societal resources (e.g., family support and relationships, economic self-sufficiency, and political power).

The basis of the social factors perspective lies in epidemiological surveys in different settings nationally and over several decades. A landmark North American study was done by Neugarten and Kraines (1965), who found in women

between the ages of 13 to 65 that a majority of the symptoms were attributed to psychological problems at puberty. However, at menopause, these same symptoms were seen as biological or physiological. They also found that there was no significant difference in subjective psychological or somatic symptoms between pre-menopausal and post-menopausal women.

The Feminist Perspective

A third potential approach in the treatment of depression in late-middle age women is the feminist perspective. Brown (1984) proposes that feminist therapy is a philosophy rather than prescriptive technique. Two principles underlie the feminist approach. First, therapy must take into consideration women's experiences in their culture and sees this culture as socially constructed and devalued as a result of pervasive sexism that affects women's lives in subtle and overt ways. Second, feminist therapists believe in the importance of attending to power relationships with an emphasis on developing egalitarian relationships.

There is no single definition of feminist therapy, but there is a general agreement about its underlying

assumption. The first is that all human beings are naturally growing and developing and are shaped by social structures (economics and institutions) and by cultural patterns (Wetzel, 1984). Also, underlying feminist theory is a single standard in which everyone has personal power: the power to be and to become. Yet no one gender (or race) has power over another.

Feminist therapy recognizes that society imposes restrictive roles on both women and men that block them in their development. Both need to be nurtured and allowed to develop to be whole and responsible. This dualistic system has placed women at a lower end of win-lose continuums which are dominant-submissive, independent-dependent, leader-follower, active-passive, powerful-powerless, and strong-weak. A woman of color falls at the end of the political scale. Women may fall victim to so-called involuntional depression. This is particularly likely to happen when children, by their own growth and movement, show that they do not need mother anymore. Women in these depressions have a great deal of anger, too, although they usually find it impossible to admit it to themselves. How can we understand such anger when children are only doing what they are supposed to do? (Baker Miller, 1986)

Feminists also point out that women themselves have internalized the norms of society and are unaware of the dualistic system. They are in the position of identifying with a reference group that stymies them because they live with a dominant male reference group. Their self-esteem, and self-acceptance is, therefore, based on male opinion and male approval.

Women's depression is strongly linked with denial of their lot and oppressive situation. Pearlin (1975) found that women who were invested equally in both work and family roles to be in conflict and depressed.

Feminist therapy would not counsel a woman (or a man) to divest herself of work interest or family interest. Rather, she would focus on consciousness raising to break through the denial block. Resolution would not come about until she becomes aware of the conflict between her social-role and position, cultural expectations and norms, and her emerging need for individuation. Through her new recognition of dysfunctional cultural influences that inhibit her development, she can gain control and explore her lifestyle and choices available to her. By reflecting on her values, she can gauge where she wants to focus her energies, what she wants to keep, and what she wants to

revise. Inherent in this perspective is a woman's inherent right to personal power - the power to be and become.

All available previous studies concern the treatment of depressed women. However, no study has been found which assesses discrepancies in Social workers' perceptions of their theoretical formulations of the causes and treatment of depression in later middle-age women and the treatment processes they actually follow.

As a profession, social work proposes the biopsychosocial model as the foundation of direct practice. The current study proposes that social workers are more likely to approach the treatment of depression in late middle age women from either the medical model or the social factors model. A minority will identify with feminist practice. Therefore it is hypothesized that:

1. A majority of respondents will report that their practice is based in social factors theory;
2. A majority of male respondents will actually practice in the medical model;
3. A majority of female respondents will practice in the social factors model with a minority who include feminist philosophy;

METHODS

Paradigm

The paradigm of the study was positivist. Positivism allows the researcher to form time- and context-free generalizations. It is essential for the inquirer to adopt a non interactive posture with the subjects of study. The methodological implications of this paradigm include questions and hypothesis stated in advance and subject to manipulation by the researcher for empirical falsification. The design of this study is correlational with a single block design. In such a design, a single population whose members share characteristics significant to the study is subjected to tests and measures wherein the independent variable is controlled.

Sampling

The population for this study selected from the population of members of the National Association of Social Workers in two counties in California. The proposed sample totaled 300 respondents. The first 100 women and the first 200 men were selected from an alphabetical mailing list which was also keyed to indicate the gender of the

addressee. The researcher assigned each potential participant a number from 1 to 300 which corresponds to the NASW mailing list of members. This sampling frame was used because it was the most complete list of social workers available for the student research project.

Instrument and Data Collection

Instrument The instrument consisted of a case presentation of a late-middle aged woman. The vignette had the presenting problem, health history, mental status assessment, social and occupation history, and diagnostic impression and summary, from which respondents answered treatment questions (See Appendix A). The questionnaire was a forty-two item self-report inventory (SRI). This instrument measured social workers' perception of their theoretical formulations (See Appendix B). The format consisted of closed-ended questions answered on a Likert type scale which ranged from one (strongly disagree) to five (strongly agree). Questions regarding treatment issues and approaches were randomly mixed and asked in different fashions. Demographic data included age, gender, ethnicity, practice setting, practice specialization, social work degree, and income. Respondents were asked to identify

their theoretical orientations and any reference they had used in preparing treatment plans. These were recorded as a descriptive picture of the respondents. The SRI was created for this study. The vignette and survey questions were created in consultation with professional social workers in public agencies. The instrument was pre-tested on volunteers from a convenience sample of CSUSB students and social workers known to the researcher.

Strengths and Weaknesses The two advantages of using a SRI are: a) large amounts of information can be solicited in a uniform manner, and b) a large sample population can be surveyed simply and in a short space of time. Participants could respond to the forty-two items in approximately thirty minutes without time-consuming face-to-face contact with the researchers. The major weaknesses of SRI's involve reliability and validity. Reliability and validity are generated from consistent test and retest answers over time. Reliability addresses consistency of answers to an instrument across time and across similar populations. Validity addresses the extent to which an instrument actually measures what it proposes to measure. Because this is the first use of the questionnaire, reliability and

validity are not addressed. Another major weakness of mail-out surveys the possibility of a low completion rate.

Other weaknesses of SRI's are their tendency to miss reporting on relevant issues because the items are preselected by the researcher. SRI's also may not capture the internal or motivational characteristics of the respondent. Therefore, this study cannot address a causative relationship between responses to the survey and social worker's clinical practice or their ethical commitment to the profession.

Procedure Data was collected using a one-time only mail out survey. The initial mailing was followed by one-time mail out reminder postcard. The expected time duration for return of the surveys was limited to six weeks. The anonymous questionnaires were returned by mail to a post office box.

Protection of Human Subjects To maintain the confidentiality and anonymity of human subjects, personal names were not be collected on completed questionnaires. A document labeled "informed consent" constituted the front page of the survey (See Appendix C). It described the

purpose, procedure, risk, and benefits of participation of the study and requested the signature of the respondent as evidence of consent to participate and understanding of the study. Upon receiving the completed questionnaires, the "informed consent" sheets were removed and maintained separately from the questionnaire by the researcher. Subjects were given, through separate documentation, a debriefing statement with the telephone number of the faculty project adviser at CSUSB (See Appendix D). Through this contact, subjects were able to obtain information about the project or discuss the survey. There were no anticipated risks to humans as a result of completing this questionnaire.

DATA ANALYSIS

The principle concept of this study was that there is a discrepancy between social workers' theoretical orientation to late middle-age depressed women and their actual treatment approaches. Theoretical orientations explored fell into three general categories. They were biological, social, and feminist factors.

Using the Statistical Package for Social Sciences (SPSS), version 6.1 for Windows, various statistical test were computed in order to subject the hypothesis to empirical testing. Univariate analysis of the data was confined to measures of central tendency applicable to ordinal variables. Descriptive variables identified respondents' reactions to questions about treatment from the three theoretical orientations. Individual variables were aggregated in order to measure responses to the theoretical orientations. Bivariate analyses of questionnaire responses (without demographic data) included the Pearson correlation and the chi-square with the gamma statistic and computations of Kendall's Tau-b and Tau-c.

RESULTS

Demographic Characteristics

Three-hundred questionnaires were mailed. Of those, 53 were returned completed which yielded a 19 percent response rate. The demographic information solicited was gender, age, ethnicity, practice setting, practice specialization, certification, social work degree, income, theoretical orientation, and references consulted (See Appendix B). Seventy five percent (N= 42) of the respondents were male; twenty five percent (N=14) were female.

The largest number of respondents were over 40 years old, a total of 35% (N=20). Most of the men were in their 40's at 37% (N=16). However, a larger percentage of the women, 40% (N=6) were in their 40's. Respondents were primarily Caucasian; that is 83% (N=47). There were 5% (N=3) Hispanic or Latino respondents, African Americans and Asian/Pacific Islanders each represented 4% (N=2) of the respondents. Native Americans and respondents self identified as "other" were 2% (N=1) of the sample.

A majority of the sample identified three practice settings. Twenty-six percent (N=15) worked in non-medical public agencies. Private clinical practice and medical and

hospital settings claimed 25% (N=14) each. Other settings were education and research at 9% (N=5) and administration respondents at 5% (N=3). Nine percent of the respondents (N=5) identified more than one area, primarily showing a private practice with another setting.

When asked to define their area(s) of specialization, 34% (N=19) identified with individual and group clinical work. Another 30% (N=17) stated they were generalist in social work. Nineteen percent (N=11) preferred marital and family work. A small 5% (N=3) were involved in organizational and community social work.

A majority of the respondents identified these licensure, certification and degree levels: fifty-six percent (N=32) as a LCSW, 19% (N=11) as a associate and 25% (N=14) did not have a license. In the level of certification category, 25% (N=14) had a ACSW, another 25% (N=14) had a BCD, and 51% had no certification. Eighty-one percent (N=46) reported having a MSW, 3% (N=2) reported having a BSW, 5% (N=3) reported having a Ph.D. or a DSW, 2% (N= 1) reported being a BSW student and 9% (N= 5) reported being a MSW student.

When asked what theoretical orientation was nearest to their own, 19% (N=11) of the respondents reported

psychoanalytic / psychodynamic as nearest to their own orientation, 5% (N=3) reported ego psychology, 3% (N=2) reported object relations / self psychology, 1.6 % (N=1) reported feminist theoretical orientation, 26% (N=15) reported cognitive-behavioral. The highest percentage 37% (N=21) reported the use of systems approach and the least, 2% (N=1), an biophysiological orientation.

Table 1 shows the percentages of the respondents indicating their theoretical orientation based on the choices given in the questionnaire. Fifty-five percent of the women reported their theoretical orientation is in biological, 40 % in social, and 5% in feminist category. Sixty-nine percent of the men reported their theoretical orientation is in biological, 30.2 % in social, and 0% in feminist category.

Table 2, shows mean scores for total sample, males, and females on actual practice approaches used based on responses to the case scenario in the questionnaire. The scores were aggregated by adding scores from a 5 point Likert scale for items reflecting each orientation. For biological there were 7 questions with a Likert scale ranging from 1-5, from which scores could range from 7-35; in social there were 10 items, from which scores could range

from 10-50; and in feminist there were 11 items, from which scores could range from 11-55. The results indicate an even distribution in actual use of various orientations, regardless of what respondents stated they practiced.

Table 3, shows the mean scores on the total sample for actual practice approach used compared to stated theoretical orientation. The results continue to indicate a even distribution of percentages in biological, social, and feminist approaches used, regardless of stated orientation.

There was notable difference in the feminist category between reported theoretical approach and actual practice approach. Males responded 40.5 % in the feminist category (table 3) in contrast to 0% (table 1) and females responded 40.1 % (table 3) in contrast to 5% (table 1) where they reported their theoretical orientation. The finding that considerable males and females used feminist approach lead to question when education influenced labels used by practitioners. Age of practitioners was used as a surrogate for when they are likely to have received their education.

Table 4 shows a Pearson correlation of practice approach by age. The results show a significant correlation between age on practice approach, for females using biological or social approaches.

TABLE 1
Theoretical Orientation of the Total Groups,
Male and Female Social Workers (N= 53)

	TOTAL (53)	MALES (39)	FEMALES (14)
Biological	65% (41)	69% (30)	55% (11)
Social	33.3% (24)	30.2% (13)	40% (11)
Feminist	1.6% (1)	0% (0)	5% (1)

TABLE 2
Mean Scores for the Total Group on Practice Approach
by Theoretical Orientation

Orientations:	Biological	Social	Feminist
Approaches:			
Biological	40.3	44.0	39.8
Social	38.4	41	39.5
Feminist	40.6	44	40.0

TABLE 3
Mean score for the Total, Males and Females on
Actual Practice Approaches Used

	TOTAL GROUP (N=53)	MALES (N=39)	FEMALES (N=14)
Biological	40.2	39.7	41.6
Social	38.8	38.8	39.9
Feminist	40.4	40.5	40.1

TABLE 4
Pearson Correlation of Practice Approach by Age

	TOTAL	MALES	FEMALES
Biological	.1481	.0114	.7591**
Social	.1432	-.0087	.6698**
Feminist	.0331	-.0433	.1969

P ≤ .05
**P ≤ .01

Hypothesis One

The first hypothesis proposed that a majority of respondents will report that their theoretical orientation

is based in social factors theory (See table 1).

The results indicated that this hypothesis is not supported; more respondents reported that their theoretical orientation was biological (65 percent). In addition, more respondents actually practiced in biological orientation.

Hypothesis 2

A majority of male respondents will actually practice in the biological model (See Table 2).

The results indicated that hypothesis was not supported. Males mean scores were slightly lower than females for biological practice approach. Males mean score resulted in; 39.7 vs. 41.6 for females, and for the total group 42.2 percent. Social Factors males scored 38.8 percent, females 39 percent, and the total group 40.2 percent.

Hypothesis 3

A majority of female respondents will practice in the social factors model with a minority who include feminist philosophy (See Table 2).

Hypothesis 3 was not supported; i.e. the majority of females did not practice in social factors (39%) but rather in the biological practice approach (41.1%).

Feminist category males scored slightly higher than

females. Males scores resulted in; 40.5 percent, females 40.1 percent and the total group scored 40.4 percent.

DISCUSSION

The study's findings did not prove to be statistically significant. On the other hand, it did show that attitudes change (men's and women's), without changes in the words used to express those attitudes. The most interesting finding is that men use the feminist approach as much or more than women.

The feminist philosophy has been influencing the counseling profession by rethinking premises and models of what was thought as normal development, the development of new approaches in research and practice(Gilbert, 1991). Past researchers failed to consider women separate from males which emerged from societies value of males' behavior over females(Jacklin & Chang, 1991).

CONCLUSION

The results indicate there were no statistically significant findings in support of the proposed hypothesis. This could mean questions were posed in a leading manner and respondents tended to agree more frequently with practice approach viewed as desirable. However there were trends in the responses given. For example; the first hypothesis proposed respondents would reported their theoretical orientation in the social factors model. Historically, the social work profession emerged from the social welfare institutions in the 19th century, which is related to economic, social, intellectual patterns, and our political history (Popple, 1995,p. 2282); and has been the hallmark of the social work profession. As practitioners, historically to present, the social work profession's focus is in environmental, social and individual issues, hence the hypothesis that respondents would report their theoretical orientation in social factors model. The results indicate that respondent's in fact, identified more with the biopsychosocial.

The second hypothesis proposing that males would practice in the biological model was not supported.

Surprisingly, women actually practiced in the biological model than their males counterparts, and this was especially true for older women. This could be an indication of the time at which most female respondents were educated, and they terms they were socialized to use.

Lastly, the third hypothesis was partially supported. The majority of females respondents did not practice in social factors but rather in the biological practice approach. More surprising, males as much or more than females, practiced in the feminist approach, but neither males or females admitted to using it. Further studies on practitioners' theoretical orientation and practice approach are needed to understand this unexpected shift of attitudes among both men and women.

APPENDIX A: CASE PRESENTATION

Presenting Problem

Ms. S is a late middle age Caucasian woman who is self-referred for treatment. She has been exhibiting signs and symptoms of depression. These include sleep and appetite disturbances, self-isolation, and statements of helplessness and hopelessness. She has agreed to psychiatric evaluation and use of anti-depressant medications, if necessary. She declined consent for anti-anxiety or anti-psychotic medications. She has agreed to participate in individual therapy at a frequency of one session per week.

Health History

Ms. S. has a current diagnoses of adult onset diabetes mellitus, mild hypertension, and hypothyroidism. She reports that her last menstrual period was when she became pregnant with her only child and that her periods never resumed. However, she has recently experienced spotting, with breast tenderness and discharge. Her current medications are Glucophage, Synthroid, Lasix, Slo-K, and Estradiol. She wears eyeglasses but experiences no difficulty with hearing or ambulation. She states she has

lost about 25 pounds in the last six weeks without dieting.

Mental Status Assessment

Ms. S. appeared for the interview voluntarily and provided information as it was requested by answering direct questions. She was reserved and guarded and did not spontaneously add information to that which was solicited. Her affect was blunted, stable, and with a restricted range. It was grossly appropriate to the circumstances of the interview. Mood, by patient report, was "very depressed." Speech was well paced, soft, and in a monotone. There was some hesitation evident of slowed thinking. Though processes were unremarkable. Thought content revealed depressive cognitions, feelings of helplessness and hopelessness, increased concern over her physical health, and recurrent statements that these feelings are unusual for her. The patient denied suicidal or homicidal ideations or plans. She also denied hallucinations or delusions and did not appear to be responding to internal stimuli. Recent and remote memory appear intact. Insight and judgment are unimpaired. Globally, this lady appears to be of above-average intelligence.

Social and Occupational History

Ms. S. was born in Lamar, Colorado, and grew up in that rural community. She is the middle child of three siblings, and the only girl. She and her brothers were raised by their own parents on the family wheat farm. She recalls enjoying her childhood and remembers specifically learning to operate the combine and to drive the grain truck at age 10. She graduated from high school and pursued university studies.

During her early college years, she worked as a "carhop" in a drive-in restaurant and in retail sales, electing to leave farming to her brothers. In spite of "negative input" from her family, she moved to Berkley, California and pursued graduate and post-graduate studies and holds a doctoral degree in social work. She currently holds a non-tenure track lecturer position at a state university. She is the only member of her family to have completed any post-secondary education.

Ms. S. was divorced from her abusive husband approximately seven years ago. They have joint legal custody of their child. Primary physical custody is to the child's father. Ms. S. pays both child support and alimony monthly. Primary custody of the child was changed from

Ms. S. to her ex-husband approximately two years ago in a legal action initiated by the ex-husband. Ms. S. believes that this is because her current intimate relationship is with a woman. Her partner has no children. Ms. S. expresses frequent guilt and grief over the loss of custody of her child.

Ms. S. states that her relationship is "being stressed" because of custody issues and loss of contact with her family. Support from her colleagues is mixed. She states she has been "disowned" by her brothers and their families and by her aged parents. Socially, Ms. S. states that she and her partner "don't do much" since the onset of her depression. She attends to her academic duties and then goes "home to become a couch potato." Formerly, the couple attended lectures, theater, and enjoyed weekend travel. Since the onset of the depression, Ms. S. states that life "tastes like cardboard."

Diagnostic Impression and Summary

Axis I: 296.22 Major depressive disorder, single episode, moderate with melancholic features.

Axis II: V71.09 No diagnosis

Axis III: AODM, HTN, hypothyroidism, amenorrhea (by patient report).

Based on the information in the case presentation, please fill in Axis IV and V:

Axis IV: _____

Axis V: _____

APPENDIX B: QUESTIONNAIRE

Please circle the following questions about yourself. **DO NOT WRITE IN THE RIGHT COLUMN.**

Demographics:

1. Age: _____

2. Gender: M F

3. Ethnicity:

1. African American
2. Asian / Pacific Island
3. Native American
4. Hispanic / Latino
5. Caucasian
6. Other

4. Practice Setting:

1. Private clinical
2. Medical / Hospital
3. Administration
4. Policy / Legislation
5. Education / Research
6. Public agency (non-medical)

5. Practice Specialization:

1. Generalist / None
2. Marital / Family
3. Individual / Group
4. Organizational
5. Community

6. Level of licensure:

1. LCSW
2. Associate
3. None

7. Certification:

1. ACBSW
2. ACSW
3. BCD
4. None

8. Highest social work academic degree:

1. BSW
2. MSW
3. Ph.D. / DSW
4. Student BSW
5. Student MSW

9. Income:
1. Less than \$20,000
 2. \$20,000 - 29,999
 3. \$30,000 - 39,999
 4. \$40,000 - 49,999
 5. \$50,000 - 59,000
 6. \$60,000 and over
10. What theoretical orientation is nearest to your own?
1. Psychoanalytic / Psychodynamic
 2. Ego psychology
 3. Object relations / Self psychology
 4. Feminist standpoint
 5. Cognitive-behavioral
 6. Systems approach
 7. Biophysiological
11. What references would you normally consult in preparing a treatment plan based on the case presentation?
1. DSM-III R
 2. DSM-IV
 3. PDR
 4. PIE
 5. Standardized agency / facility treatment plans
 6. Standardized test / inventories: _____
-

Please answer the following questions based on the case presentation by circling the appropriate number. Please do not leave any blanks. DO NOT WRITE IN GRAY AREA.

12. The client's physical symptoms should be medically stabilized before initiating any form of psychotherapy.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

13. Addressing the client's cognitions and behaviors is the foundation of therapy.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

14. Reframing the client's depressive cognitions and changing self defeating behaviors is the purpose of therapy.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

15. Role loss issues are an essential theme.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

16. Societal norms are an important issue to address in therapy.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

17. It is important to assist the client in making her work relationships supportive to her growth.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

18. Selective sharing is an important tool in the therapeutic process.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

19. The client should be referred to a medical doctor for a complete physical and laboratory evaluation.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

20. It is more important to focus on the client's present relationship to her family than on past problems.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

21. Self disclosure aids the establishment of the therapeutic alliance.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

22. The client should be encouraged to identify and verbally express her feelings.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

23. Child custody and spousal support are important social issues for this client.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

24. Oppression is an important issue when dealing with a female client.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

25. Medication is an important adjunct in treating this client.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

26. Self disclosure should be avoided.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

27. Facilitating the client's own growth process is the aim of the therapeutic relationship.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

28. The client should be encouraged to discuss separation from her child and the child's father

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

29. Past childhood issues are important to explore.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

30. It is important to acknowledge the client's potential discomfort with social norms.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

31. Coping with depression rather than growth is the purpose of therapy.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

32. A consistent theme will be mid-life development.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

33. The client's collegial relationships should be the first or second priority of therapy.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

34. Roles and relationships in the client's original family have a present impact on her depression.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

35. The client should take steps to get in touch with her anger and sadness.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

36. The client's primary relationship should support and be supported by therapy.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

37. The client should resume her previous social activities

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

38. Selective sharing will blur boundaries in the therapeutic process.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

39. Mid-life issues are specious.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

40. Social norms should only be addressed if the client raises them.

strongly disagree	disagree	undecided	agree	strongly agree
1	2	3	4	5

41. What other issue would you address?

42. What age did you think the client is? _____

APPENDIX C: Informed Consent

Dear NASW Member:

Enclosed are a vignette and a questionnaire which attempt to discover the process by which social workers assess depression in late- middle age women. The questionnaire has been mailed to three hundred randomly selected members of Region F. Although many social workers are being surveyed, **your participation is critical to the success of the study.** Since each unreturned questionnaire reduces the generalizability of the study a high response rate is necessary to identify your views accurately and lend value to the study.

Please be assured your responses are completely anonymous. The vignette and questionnaire you received are numbered. Please **do not** include your name on the questionnaire. The mailing list and completed surveys will be maintained separately. At the close of the data collection period the mailing list will be destroyed. There is no way for anyone to identify who returned any given questionnaire. Also, there are no correct or incorrect responses in this survey. A summary of the findings will be available on request at the close of the projects.

You have the right to choose not to participate in this study or to withdraw your responses at any time before June 14, 1996. Your participation in this study is completely voluntary. There will be no remuneration for your participation; there is no financial gain to Enid A. Velasco, the researcher.

If you have questions regarding the nature and content of this study, please contact Rosemary McCaslin, Ph.D., faculty project adviser at California State University, San Bernardino, CA. She may be contacted by telephone at (909) 880-5501.

In the interest to contributing to the knowledge base of the evaluation of social work practice, in the interest of assisting a potential social worker in completing her degree program, and to contribute to the success of this survey would you kindly take about 15 minutes from your already busy schedule to complete the enclosed questionnaire and return it in the enclosed stamped self-addressed envelope.

Please try to return this questionnaire as soon as possible and **no later than June 30, 1996**. Please keep one copy of this letter for your files. Thank you for your participation.

Enid A. Velasco

My signature represents my informed consent to participate in the above described study.

Participant's Name

Signature

Date

Circle one if you want a summary . **Yes**

No

If yes, please send a self addressed, stamped envelope.

APPENDIX D: Debriefing Statement

Dear Study Participant:

Thank you for your participation in the study conducted in partial fulfillment of the requirements of the Master of Social Work degree by Enid A. Velasco. The research was conducted with the approval of the Department of Social Work, California State University, San Bernardino, CA. One of the facets the survey sought to discover was the processes by which social workers assess depression in late-middle-age women.

Another purpose of the study was to examine differences in social workers' perceptions of their formulations of the causes and treatment of the depression in late-middle-age women and the treatment processes they follow. A summary of the results is available on request. Please be assured your responses are completely anonymous. There is no way for anyone to identify who returned any given questionnaire.

If you have any questions regarding the nature, content, or results of this study please contact Rosemary McCaslin, Ph.D., faculty project advisor at California State University, San Bernardino, CA. She may be contacted by telephone at (909) 880-5501. Thank you again for your participation.

Enid A. Velasco

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